BANKERS INSURANCE COMPANY

P.O. Box 27267 Minneapolis, MN 55427-0267

Statement of Claim

Please refer to your Identification Card for the toll-free Member Services telephone number.

TO BE COMPLETED BY THE INSURED/PATIENT

Patient's Name:	Date of Birth:	Gender:

Identification Number	Relationship of Patient to Insured ☐ Self ☐ Spouse ☐ Dependant
Is Patient a Full-Time Student? ☐ Yes ☐ No	If Yes, provide College Name and Address

Insured's Street Address	Telephone Number	E-mail Address

Patient's Employer	Work Telephone

Is claim related to:	Employment? ☐ Yes ☐ No	Auto Accident? ☐ Yes ☐ No	Other Accident? ☐ Yes ☐ No

MEDICAL CLAIM - TO BE COMPLETED BY PHYSICIAN OR SUPPLIER

Date of Service	Place of Service	Procedure Code	Description of Services	Type of Service	Charges	Days or Units	Diagnosis Code

Physicians Name	Telephone Number	Taxpayer Identification Number

Address	National Provider Identifier	Total Charges

Signature of Physician:______________________________ Date:______________

PHARMACY CLAIM - TO BE COMPLETED BY INSURED/PATIENT

Name of Pharmacy	Address	Telephone Number	Compound Prescription? ☐

Date Filled	Rx Number	Rx	Quantity	Days Supplied	National Drug Code (NDC)	DAW Code	Rx Price
		☐ New ☐ Refill			| | | | | | | | | |	☐0 ☐1 ☐2 ☐3 ☐4 ☐5	

Medication Name, Strength, and Dosage Form	Prescribing Doctors Name and DEA Number

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Medication Name, Strength, and Dosage Form	Prescribing Doctors Name and DEA Number

AUTHORIZATION - TO BE COMPLETED BY INSURED/PATIENT

I/We certify that the above information is true and correct. I/We authorize Bankers Insurance Company, organization, employer, hospital, physician, pharmacist, or other health care provider to release any information requested in connection with the filing of this claim and the expenses reported. *Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony in the third degree.*

Patient/Insureds Signature:______________________________ Date:______________